PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D08

PROVIDER-
Nathan Littauer Hospital

Provider No.: 33-0276

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

RECORD HEARING DATE –
June 28, 2023

Cost Reporting Period Ended –
12/31/2011

CASE NO. – 16-2145

INDEX

ISSUE STATEMENT

Whether the Medicare Contractor properly calculated the volume decrease adjustment ("VDA") owed to Nathan Littauer Hospital ("Nathan Littauer" or the "Provider") for the significant decrease in inpatient discharges that occurred during its cost reporting period ending December 31, 2011 ("FY 2011").[1]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor improperly calculated Nathan Littauer's VDA payment for FY 2011 and that Nathan Littauer should receive an additional VDA payment of $1,171,726 for FY 2011, resulting in a total FY 2011 VDA payment of $2,263,056.

INTRODUCTION

Nathan Littauer is located in Gloversville, New York. Nathan Littauer was designated as a Medicare Dependent Hospital ("MDH") during the fiscal year at issue.[2] Nathan Littauer's assigned Medicare contractor[3] is National Government Services ("Medicare Contractor").

Nathan Littauer requested a VDA adjustment to compensate it for a decrease in inpatient discharges during FY 2011 and, at that time, calculated that it is due a VDA payment of $3,908,531 for FY 2011.[4] On May 27, 2016, the Medicare Contractor agreed that Nathan Littauer qualified for a VDA and calculated the FY 2011 VDA payment to be $1,091,330.[5] On June 20, 2016, Nathan Littauer requested a reconsideration of the Medicare Contractor's initial VDA calculation on the basis that the methodology was inconsistent with the regulations.[6] On July 11, 2016, the Medicare Contractor "affirmed its previous calculation and denied the Provider's request for an additional VDA payment."[7] As it still disagreed with the Medicare Contractor's final VDA payment calculation, Nathan Littauer timely appealed the Medicare Contractor's final decision and met all jurisdictional requirements for a hearing before the Board.

The Board approved a record hearing on June 28, 2023. Nathan Littauer was represented by Richard S. Reid of The Rybar Group, Inc. The Medicare Contractor was represented by Scott Berends, Esq. of Federal Specialized Services.

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[1] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 3.
[2] Stipulations at ¶ 1.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs, as appropriate and relevant.
[4] Exhibit P-1. *See also* Provider's Final Position Paper (hereafter "Provider's FPP) at 2; Stipulations at ¶ 5.
[5] Medicare Contractor's FPP at 4; Exhibit P-2.
[6] Exhibit C-3 at 2.
[7] Medicare Contractor's FPP at 4. *See also* Exhibit C-4.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare pays certain hospitals a predetermined, standardized amount per discharge under the inpatient prospective payment system ("IPPS") based on the diagnosis-related group ("DRG") assigned to the patient. These DRG payments are also subject to certain payment adjustments.

One of these payment adjustments is referred to as a VDA payment and it is available to MDHs if, due to circumstances beyond their control, they incur a decrease in their total number of inpatient cases of more than 5 percent from one cost reporting year to the next. VDA payments are designed "to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services."[8] The implementing regulations, located at 42 C.F.R. § 412.108(d), reflect these statutory requirements.

As confirmed in the determination being appeal, it is undisputed that Nathan Littauer experienced a decrease in discharges greater than 5 percent from FY 2010 to FY 2011 due to circumstances beyond its control and that, as a result, Nathan Littauer was eligible to have a VDA calculation performed for FY 2011.[9] Nathan Littauer asserts that it is entitled to a VDA payment in the amount of $2,278,466 for FY 2011.[10] However, when the Medicare Contractor made the FY 2011 VDA calculation, it determined that Nathan Littauer was entitled to a VDA payment of $1,091,330, after removing the cost it had identified as variable.[11] Thus, this appeal addresses whether Nathan Littauer is due an additional VDA payment and, in particular, the parties' dispute regarding how the total VDA payment should be calculated.

The implementing regulations are located at 42 C.F.R. § 412.108(d). When promulgating § 412.108(d), CMS made it clear that the VDA rules for MDHs were identical to those already in effect for sole community hospitals ("SCHs").[12] The regulation at 42 C.F.R. § 412.108(d) directs how the Medicare Contractor must determine the VDA once an MDH demonstrates that it experienced a qualifying decrease in total inpatient discharges. Specifically, § 412.108(d)(3) (2011) states, in pertinent part:

> (3) The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs hospitals that serve a disproportionate share of low-income patients as determined under §412.106 and for indirect medical education costs as determined under §412.105).

[8] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[9] Stipulations at ¶¶ 2-3.
[10] *Id* at ¶ 7.
[11] *Id* at ¶ 10.
[12] 55 Fed. Reg. 15150, 15155 (Apr. 20, 1990). *See also* 71 Fed. Reg. 47870, 48056 (Aug. 18, 2006).

> (i) In determining the adjustment amount, the intermediary considers –
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> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
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> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter...; and
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> (C)The length of time the hospital has experienced a decrease in utilization.[13]

In the preamble to the final rule published on August 18, 2006,[14] CMS referenced the Provider Reimbursement Manual, Pub. No. 15-1 ("PRM 15-1") § 2810.1 (Rev. 371), which provides further guidance related to VDAs and states in relevant part:

> B. Additional payment is made . . . for the fixed costs it incurs in the period in providing inpatient hospital services including the reasonable cost of maintaining necessary core staff and services, not to exceed the difference between the hospital's Medicare inpatient operating cost and the hospital's total DRG revenue.
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> Fixed costs are those costs over which management has no control. Most truly fixed costs, such as rent, interest, and depreciation, are capital-related costs and are paid on a reasonable cost basis, regardless of volume. Variable costs, on the other hand, are those costs for items and services that vary *directly* with utilization such as food and laundry costs.[15]

The chart below depicts how the Medicare Contractor and Nathan Littauer each calculated the FY 2011 VDA payment.

[13] (Emphasis added.) *See also* 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[14] 71 Fed. Reg. at 47870, 48056 (Aug. 18, 2006).
[15] (Emphasis added.)

	Medicare Contractor calculation using fixed costs[16]	Provider/PRM calculation using total costs[17]
a) Prior Year Medicare Inpatient Operating Costs	$ 10,273,271	$ 10,273,271
b) Percent of Fixed & Semi-fixed to Total Costs	88.71%[18]	
c) IPPS update factor	1.0235	1.0235
d) Prior year Updated Operating Costs (a x b x c)	$ 9,327,557	$ 10,514,693
e) Current Year Program Operating Costs	$ 11,567,614	$ 11,567,614
f) Percent of Fixed & Semi-fixed to Total Costs	86.82%	100.00%[19]
g) Current Year Maximum Allowable Cost (e x f)	$ 10,043,002	$ 11,567,614
h) Lower of d or g	$ 9,327,557	$ 10,514,693
i) DRG/MDH payment	$ 8,236,227	$ 8,236,227
j) VDA Payment Cap (h-i)	$ 1,091,330	$ 2,278,466
k) Current Year Inpatient Operating Costs	$ 11,567,614	
l) Current Year Fixed Cost percent	86.82%[20]	
m) FY 2011 Fixed Costs (k x l)	$ 10,043,002	
n) Total DRG Payments	$ 8,236,227	
o) VDA Payment (Not to Exceed Cap Above) (m-n)	$ 1,806,775	
p) Lessor of Cap or VDA Payment	$ 1,091,330	

The parties to this appeal dispute the application of the statute and regulation used to calculate the VDA payment.[21]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

The Medicare Contractor and Nathan Littauer do not dispute that Nathan Littauer met the criteria qualifying it for a VDA calculation to be completed by the Medicare Contractor. However, they disagree as to the method to calculate the amount of the VDA payment, in accordance with the statute and regulations.[22]

A. The Medicare Contractor's Position

The Medicare Contractor disagrees with Nathan Littauer's first assertion that an error in calculating the VDA ceiling occurred.[23] Specifically, the parties' stipulations states:

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[16] Stipulations at ¶ 10.
[17] *Id* at ¶ 7.
[18] The MAC "acknowledges that the application of the fixed cost percentage to the PY Inpatient Operating Costs is not in accordance with the calculation described in the FY 2009 IPPS Final Rule and is willing to update the calculation of the VDA ceiling pending the Board's decision in the other matters at issue in this appeal." *See also* Medicare Contractor's FPP at 17.
[19] Nathan Littauer does not remove variable costs from the VDA calculation, stating that variable costs are not removed in any of the examples in PRM 2810.1, nor in the Federal Register published in 2008. Provider's FPP at 7.
[20] Total Expenses per Worksheet A, less Variable Expenses, divided by Total Expenses per Worksheet A (Calculation = ($86,212,427 – 11,367,045)/$86,212,427 = 0.8681507366), rounded to 0.8682. *See also* Exhibit C-2 at 8.
[21] Stipulations at ¶ 13; Medicare Contractor's FPP at 7.
[22] *Id*.
[23] Medicare Contractor's FPP at 9.

> [t]he VDA ceiling calculation is described in PRM 2810.1, and has been affirmed several times since publication, most recently by the Board and Administrator in Decision No. 2020-D23. The cap is calculated by subtracting total DRG revenue from the lesser of the prior year's inpatient operating costs increased by the IPPS factor, or current year inpatient operating costs. The MAC stipulates that it departed from this methodology when calculating the 2011 VDA adjustment but used this methodology in 2012. In 2011, the MAC instead compared the lesser of the Provider's fixed and semi-fixed costs from 2010 and 2011 to 2011's total DRG revenue . . . Had the MAC calculated the cap using the same method as in 2012, they would have calculated a payment of $1,806,775."[24]

Despite this departure, the Medicare Contractor stipulates its methodology for calculating the VDA at issue is consistent with "the Secretary's determination regarding the methodology for calculating the VDA in the *Unity, St. Anthony, and Lakes* Opinion."[25]

The Medicare Contractor disagrees with Nathan Littauer's second assertion that the VDA calculation at issue is an "inherently flawed methodology for calculating the Provider's VDA, which did not fully compensate the Provider for all of its fixed costs as Congress requires."[26] In support of its position, the Medicare Contractor cites to the explicit wording of the relevant statute and regulations, and refers to the Administrator's decisions in *Fairbanks Memorial Hospital v. Wisconsin Physician Services* ("Fairbanks"), *Unity HealthCare v. BlueCross BlueShield Association* ("Unity"), and *Lakes Regional Healthcare v. BlueCross BlueShield Association* ("Lakes").[27]

Further, the Medicare Contractor argues that it "determined how much of the total expenses were attributable to variable expenses and fixed/semi-fixed expenses using the documentation submitted by the Provider as the basis for the calculation."[28] Those variable expenses were excluded from the VDA calculation. The Medicare Contractor references PRM 15-1 § 2810.1(B)-(C) as support for removing variable costs in the VDA calculation. However, it also states that "the PRM [15-1] examples do not show how to apply the variable cost factor."[29] The Medicare Contractor quotes § 2810.1(B) which defines variable costs as "those costs for items and services that vary directly with utilization such as food and laundry costs." The Medicare Contractor also references 42 C.F.R. § 412.92(e), which specifically notes that intermediaries' "adjustment is limited to fixed (and semi-fixed) costs."[30] The Medicare Contractor thus asserts that this "clearly demonstrates that *variable* ***costs*** are not to be considered in the calculation of the VDA."[31] The Medicare Contractor contends that the "law is quite clear [42 U.S.C.

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[24] Stipulations at ¶ 12.
[25] *Id*. at 14.
[26] Medicare Contractor's FPP at 9.
[27] *Id.* at 12.
[28] *Id.* at 8.
[29] *Id.* at 10.
[30] *Id.* at 12.
[31] *Id.* at 15 (emphasis added).

§ 1395ww(d)(5)(G)(iii)] when it states that the payment adjustment is "[t]o fully compensate the hospital for the *fixed costs* it incurs."[32] Without any reference in the regulation to compensation for variable costs, the VDA calculation must only consider fixed and semi-fixed costs, as demonstrated by the Administrator's decisions in the *Unity, Lakes Regional,* and *Fairbanks* decisions. The Medicare Contractor concludes that "[n]either the statute nor the regulation include a reference to compensation for variable costs."[33]

B. Nathan Littauer's Position

Nathan Littauer argues that there are two issues with the Medicare Contractor's methodology. "First, the 2011 cap calculation was not consistent with recent Board and Administrator decisions. Second, Nathan Littauer contends that "NGS's methodology calculated the Provider's VDA payment by comparing the Provider's fixed program operating costs to its total DRG payment."[34] Nathan Littauer maintains that the Medicare Contractor's calculation of the VDA is wrong because it "departed from CMS' established policy and did not use the policy set forth in [§] 2810.1 of the PRM and summarized in Federal Register rulemaking."[35] Nathan Littauer argues that this policy does not mention the removal of variable costs and, "[d]espite making an earlier reference to considering fixed and semi-fixed costs, none of the examples show variable costs being removed from the calculation."[36] Moreover, Nathan Littauer contends that "[r]emoving variable costs from the calculation would make the cap defined in the Regulations, in PRM [15-1 §] 2810.1 and the calculation in the Federal Register unnecessary, as the cap would never be reached."[37] Further, Nathan Littauer maintains that [b]y removing variable costs, the Medicare Contractor "recalculated [Nathan Littauer's] inpatient operating costs as if [Nathan Littauer] did not have to provide any food, any drugs, any medical supplies, or any laundry services to its inpatients."[38]

Nathan Littauer argues that the Medicare Contractor's calculation of the VDA was incorrect because the Medicare Contractor "departed from CMS's manual instructions and step-by-step guide and added an unauthorized and monumental extra step."[39] According to Nathan Littauer, "[n]owhere in the Federal Register does it say to subtract variable costs from the [p]rovider's costs."[40] In doing so, Nathan Littauer argues that it was not fully compensated for all of its fixed costs.

The Board notes that the Final Rule published on September 1, 1983 ("FFY 1984 IPPS Final Rule")[41] states that "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period. . . . An adjustment will ***not*** be made for truly variable costs, such as food and laundry services."[42] Nathan Littauer's position is

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[32] *Id.* at 11 (emphasis added).
[33] *Id.*
[34] Provider's FPP at 5.
[35] *Id.* at 7.
[36] *Id.* at 8.
[37] *Id.*
[38] *Id.* at 7.
[39] *Id.* at 8.
[40] *Id.* at 7.
[41] 48 Fed. Reg. 39752 (Sept. 1, 1983).
[42] 48 Fed. Reg. 39752, 39781-2 (emphasis added).

that the "[d]efinition as to the process of making the payment calculation is principally provided in PRM 2810.1 and subsequently updated in the Federal Register dated August 19, 2008."[43] Nathan Littauer also maintains that its current VDA calculation is in accordance with PRM 15-1 § 2810.1 and that this was the methodology "in effect during the cost reporting period under appeal."[44]

Nathan Littauer contends that the Medicare Contractor's approach does not fully compensate the hospital for its fixed and semi-fixed inpatient operating costs and therefore is flawed. In support, Nathan Littauer asserts that "[w]hen Congress implemented the VDA, it mandated that the payment be calculated in a manner that would ensure **full compensation for all fixed costs** incurred by a hospital in providing inpatient care to Medicare recipients."[45]

C. Board Findings and Conclusions

In recent decisions,[46] the Board has disagreed with the methodology used by various Medicare contractors to calculate VDA payments because it compares fixed costs to total DRG payments and only results in a VDA payment if the fixed costs exceed the total DRG payment amount. In these cases, the Board has recalculated the hospitals' VDA payments by estimating the fixed portion of the hospital's DRG payments (based on the hospital's fixed cost percentage as determined by the Medicare contractor) and comparing this fixed portion of the DRG payment to the hospital's fixed operating costs, so there is an apples-to-apples comparison.

Referring to the methodology adopted by the Board in previous decisions, Nathan Littauer asserts that, if variable costs are to be excluded from inpatient operating costs when calculating the VDA, there should also be a corresponding decrease to the DRG payment for variable costs. Nathan Littauer states that, under the Board's methodology, its "DRG payments would have been multiplied by the percentage of fixed program costs to all program costs to calculate the DRG payments attributable to fixed costs."[47] Nathan Littauer also references the fact that CMS essentially adopted this approach when it published the 2018 IPPS Final Rule for calculating VDA payments.[48]

The Administrator has overturned these Board decisions, stating:

> [T]he Board attempted to remove the portion of DRG payments the Board attributed to variable costs from the IPPS/DRG revenue. . . . In doing so the Board created a "fixed cost percentage" which does not have any source of authority pursuant to CMS guidance, regulations or underlying purpose of the VDA amount. . . . The

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[43] Provider's FPP at 7.
[44] *Id.*
[45] *Id.* at 11.
[46] *St. Anthony Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2016-D16 (Aug. 29, 2016), *modified by*, Adm'r Dec. (Oct. 3, 2016); *Trinity Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2017-D1 (Dec. 15, 2016), *modified by*, Adm'r Dec. (Feb. 9, 2017); *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Servs*, PRRB Dec. No. 2015-D11 (June 9, 2015), *modified by*, Adm'r Dec. (Aug. 5, 2015).
[47] Provider's FPP at 12.
[48] *Id.*

> VDA is not intended to be used as a payment or compensation mechanisms that allow providers to be made whole from variable costs, i.e., costs over which providers do have control and are relative to utilization. The means to determine if the provider has been fully compensated for fixed costs is to compare fixed costs to the total compensation made to the provider. . . .[49]

Recently, the Court of Appeals for the Eighth Circuit ("Eighth Circuit") upheld the Administrator's methodology in *Unity HealthCare v. Azar* ("*Unity*"), stating the "Secretary's interpretation was not arbitrary or capricious and was consistent with the regulation."[50]

At the outset, the Board notes that the Administrator decisions are not binding precedent, as explained by PRM 15-1 § 2927(C)(6)(e):

> e. Nonprecedential Nature of the Administrator's Review Decision.—Decisions by the Administrator ***are not precedents*** for application to other cases. A decision by the Administrator may, however, be examined and an administrative judgment made as to whether it should be given application beyond the individual case in which it was rendered. If it has application beyond the particular provider, the substance of the decision will, as appropriate, be published as a regulation, HCFA Ruling, manual instruction, or any combination thereof so that the policy (or clarification of policy [*sic*] having a basis in law and regulations may be generally known and applied by providers, intermediaries, and other interested parties.[51]

The Board finds that, while Nathan Littauer is not in the Eighth Circuit and the statutes and regulations for VDAs for SCHs and MDHs are identical, these applicable statutes and regulations only provide a framework by which to calculate a VDA payment.[52] As a result, the Board is not bound to apply the specific VDA calculation methodology that the Administrator

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[49] *Fairbanks Mem'l Hosp. v. Wisconsin Physicians Serv.*, Adm'r Dec. at 8 (Aug. 5, 2015), *modifying*, PRRB Dec. No. 2015-D11 (June 9, 2015).

[50] *Unity HealthCare v. Azar*, 918 F.3d 571, 579 (8th Cir. 2019) *cert. denied*, 140 S. Ct. 523 (2019).

[51] (Bold and italics emphasis added).

[52] With regard to SCHs, 42 U.S.C. § 1395ww(d)(5)(D)(ii), *see, e.g.*, *St. Anthony Reg'l Hosp. v. Azar,* 294 F. Sup. 3d 768, 779 (N.D. Iowa 2018) (stating that § 1395ww(d)(5)(D)(ii) contains a gap as it directs that "the Secretary shall provide for such . . . payment . . . as may be necessary" and that "[t]he Secretary has filled that gap in a manner that I find to be reasonable in light of the statutory framework and purpose."), *aff.d*, *Unity HealthCare v. Azar*, 918 F.3d 571 (8th Cir. 2019). With regard to SCHs, 42 C.F.R. § 412.92(e)(3), *see, e.g., id*. at 772, 781 (adopting the Magistrate's report which found that '"[t]he regulations promulgated by the Secretary in effect during the relevant time period did not provide a specific formula for calculating the VDA payment[,]'" and '"[i]nstead, the regulation directed that the following factors be considered in determining the VDA payment amount...'"). The Board's plain reading of the regulation is confirmed by the Agency's discussion of this regulation in the preamble to rulemakings. *See*, for SCHs, *e.g.*, 52 Fed. Reg. 33034, 33049 (Sept. 1, 1987) (stating that "[w]e determine on a case-by-case basis whether an adjustment will be granted and the amount of that adjustment." (emphasis added)); 48 Fed. Reg. 39752, 39781-82 (Sept. 1, 1983).

applied (and the Eighth Circuit upheld) in *Unity*.[53] In this regard, the Board further notes that §§ 412.92(e)(3) and 412.108(d)(3) make clear that the VDA payment determination is subject to review through the Board's appeal process.[54] Thus, the Board finds that the Eighth Circuit's *Unity* decision was simply adjudicating a dispute regarding the reasonableness of the Administrator's interpretation of the statute and regulations governing VDAs that the Administrator applied in rendering her decision in *Unity*. As such, the Eighth Circuit's decision in *Unity* did not create a binding precedent as to the specific VDA calculation methodology that the Board is obligated to follow.

Significantly, *subsequent to the time period at issue*, CMS essentially adopted the Board's methodology for calculating VDA payments. In the preamble to FFY 2018 IPPS Final Rule,[55] CMS prospectively changed the methodology for calculating the VDA to one which is very similar to the methodology used by the Board. Under this new methodology, CMS requires Medicare contractors to compare the estimated portion of the DRG payment that is related to fixed costs, to the hospital's fixed costs, when determining the amount of the VDA payment.[56] The preamble to the FFY 2018 IPPS Final Rule makes this change effective for cost reporting periods beginning on or after October 1, 2017, explaining that it will "remove any conceivable possibility that a hospital that qualifies for the volume decrease adjustment could ever be less than fully compensated for fixed costs as a result of the application of the adjustment."[57]

Pursuant to 42 C.F.R. § 405.1867, the Board must give great weight to interpretive rules and general statements of policy. As set forth below, the Board finds that the Medicare Contractor's calculation of Nathan Littauer's VDA for FY 2011 was incorrect because it was *not* based on CMS' stated policy as delineated in PRM 15-1 § 2810.1 and the Secretary's endorsement of this policy in the preambles to the relevant Final Rules.

The Medicare Contractor determined Nathan Littauer's VDA payment by comparing its FY 2011 fixed costs to its total FY 2011 DRG payments. However, neither the language nor the examples[58] in PRM 15-1 compare *only* the hospital's *fixed costs* to its *total DRG payments* when calculating a hospital's VDA payment. The instructions in PRM 15-1 are similar to the preambles of both the FFY 2007 IPPS Final Rule[59] and the FFY 2009 IPPS Final Rule[60] and

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[53] *See*, e.g., *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1107-08 (D.C. Cir. 2014) (discussing regulatory interpretations adopted through adjudication versus through rulemaking).

[54] Moreover, the Board notes that, subsequent to the Eighth Circuit's decision in *Unity*, the U.S. Supreme Court issued its decision in *Azar v. Allina Health Servs*, 139 S. Ct. 1804, 1810, 1817 (2019) ("*Allina II*") where the Supreme Court ruled on the scope of Medicare policy issuances that are subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) by making clear that "the government's 2014 announcement of the 2012 Medicare fractions [to be used in DSH calculations for FY 2012 where the Agency] 'le[t] the public know [the agency's] current adjudicatory approach' to a critical question involved in calculating payments for thousands of hospitals nationwide" was a "statement of policy that establishes or changes a substantive legal standard" as that phrase is used in 42 U.S.C. § 1395hh(a)(2) and, thus, was subject to the notice and comment requirements under 42 U.S.C. § 1395hh(a)(2) (citations omitted).

[55] 82 Fed. Reg. 37990, 38179-38183 (Aug. 14, 2017).

[56] This amount continues to be subject to the cap specified in 42 C.F.R. § 412.108(d)(3).

[57] 82 Fed. Reg. at 38180.

[58] PRM 15-1 § 2810.1(C)-(D).

[59] 71 Fed. Reg. at 48056.

[60] 73 Fed. Reg. at 48631.

reduce the hospital's cost only by excess staffing (not variable costs) when computing the VDA. Specifically, both of these preambles state:

> The adjustment amount is determined by subtracting the second year's MS-DRG payment from the lesser of: (a) The second year's cost minus any adjustment for excess staff; or (b) the previous year's costs multiplied by the appropriate IPPS update factor minus any adjustment for excess staff. The SCH or MDH receives the difference in a lump-sum payment.[61]

It is clear from the preambles to these Final Rules that the only adjustment to the hospital's cost is for excess staffing. Therefore, the Board finds that the Medicare Contractor did not calculate Nathan Littauer's VDA using the methodology laid out by CMS in PRM 15-1 or the Secretary in the preambles to the FFY 2007 and 2009 IPPS Final Rules.

Rather, the Board finds the Medicare Contractor calculated Nathan Littauer's FY 2011 VDA based on an otherwise *new* methodology that the Administrator adopted through adjudication in her decisions described as follows: the "VDA [payment] is equal to the difference between its fixed and semi-fixed costs and its DRG payment . . . subject to the ceiling[.]"[62] The Board suspects that the Administrator developed this new methodology using fixed costs because of a seeming conflict between the methodology explained in the FFY 2007 and 2009 IPPS Final Rules/PRM and the statute. Notably, in applying this new methodology through adjudication, CMS did not otherwise alter its written policy statements in either the PRM or Federal Register until it issued the FFY 2018 IPPS Final Rule.[63] The Board further notes that the Medicare Contractor's cap calculation in FY 2011 was not consistent with the methodology it used for FY 2012, and that it admits to this inconsistency.

The statute at 42 U.S.C. § 1395ww(d)(5)(G)(iii) is clear that the VDA payment is to fully compensate the hospital for its fixed cost:

> In the case of a Medicare dependent, small rural hospital that experiences, in a cost reporting period compared to the previous cost reporting period, a decrease of more than 5 percent in its total number of inpatient cases due to circumstances beyond its control, the Secretary shall provide for such adjustment to the payment amounts under this subsection (other than under paragraph (9)) as may be necessary to fully compensate the hospital for the fixed costs it incurs in the period in providing inpatient hospital services, including the reasonable cost of maintaining necessary core staff and services.

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[61] 71 Fed. Reg. at 48056 and 73 Fed. Reg. at 48631.
[62] *Lakes Reg'l Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D16 at 8 (Sep. 4, 2014).; *Unity Healthcare v. BlueCross BlueShield Ass'n*, Adm. Dec. 2014-D15 at 8 (Sept. 4, 2014); *Trinity Reg'l. Med. Ctr. v. Wisconsin Physician Servs.*, Adm. Dec. 2017-D1 at 12 (Feb. 9, 2017).
[63] 82 Fed. Reg. at 38179-38183.

In the FFY 1984 IPPS Final Rule, the Secretary further explained the purpose of the VDA payment: "[t]he statute requires that the [VDA] payment adjustment be made to compensate the hospital for the fixed costs it incurs in the period. . . . An adjustment will *not* be made for truly variable costs, such as food and laundry services."[64] However, the VDA payment methodology as explained in the FFY 2007 and 2009 IPPS Final Rules and PRM 15-1 § 2810.1 compares a hospital's total cost (reduced for excess staffing) to the hospital's *total* DRG payments and PRM 15-1 § 2810.1 states in pertinent part:

> C. Requesting Additional Payments.—. . . .
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> 4. Cost Data.—The hospital's request must include cost reports for the cost reporting period in question and the immediately preceding period. The submittal must demonstrate that the Total Program Inpatient Operating Cost, excluding *pass-through costs, exceeds DRG payments*, including outlier payments. *No adjustment is allowed if DRG payments exceeded program inpatient operating cost*. . . .
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> D. Determination on Requests.— . . . . The payment adjustment is calculated under the same assumption used to evaluate core staff, i.e. *the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost*. Therefore, the adjustment allows an increase in cost up to the prior year's total Program Inpatient Operating Cost (excluding pass-through costs), increased by the PPS update factor.
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> EXAMPLE A: Hospital C has justified an adjustment to its DRG payment for its FYE September 30, 1987. . . . Since Hospital C's FY 1987 Program Inpatient Operating Cost was less than that of FY 1986 increased by the PPS update factor, *its adjustment is the entire difference between FY 1987 Program Inpatient Operating Cost* ***and FY 1987 DRG payments***.
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> EXAMPLE B: Hospital D has justified an adjustment to its DRG payment for its FYE December 31, 1988. . . . Hospital D's FY 1988 Program Inpatient Operating Cost exceeded that of FY 1987 increased by the PPS update factor, so *the adjustment is the difference between FY 1987 cost adjusted by the update factor* ***and FY 1988 DRG payments***.[65]

At first blush, this would appear to conflict with the statute and the FFY 1984 IPPS Final Rule which limit the VDA to fixed costs. The Board believes that the Administrator tried to resolve this seeming conflict by establishing a new methodology through adjudication in the

[64] 48 Fed. Reg. 39752, 39781-39782 (Sep. 1, 1983) (emphasis added).
[65] (Emphasis added.)

Administrator decisions stating that the "VDA is equal to the difference between its *fixed and semi-fixed costs* and its DRG payment . . . subject to the ceiling."[66]

Based on its review of the statute, regulations, PRM 15-1 and the Eighth Circuit's decision, the Board respectfully disagrees that the Administrator's methodology complies with the statutory mandate to "fully compensate the hospital for the fixed costs it incurs."[67] Using the Administrator's rationale, a hospital is fully compensated for its fixed costs when the total DRG payments issued to that hospital are equal to or greater than its fixed costs. This assumes that the entire DRG payment is payment ***only*** *for the* ***fixed*** *costs* of the services *actually* furnished to Medicare patients. However, the statute at 42 U.S.C. § 1395ww(a)(4) makes it clear that a DRG payment includes payment for both fixed *and* variable costs of the services rendered because it defines operating costs of inpatient services as "**all** routine operating costs . . . and includes the ***costs*** *of all services* for which payment may be made[.]" The Administrator cannot simply ignore 42 U.S.C. § 1395ww(a)(4) and deem all of a hospital's DRG payments as payments solely for the fixed cost of the Medicare services actually rendered when the hospital in fact incurred both fixed and variable costs for those services.

Indeed, the Board must conclude that the purpose of the VDA payment is to compensate an MDH for all the fixed costs associated with the qualifying volume decrease (which must be 5 percent or more). This is in keeping with the assumption stated in PRM 15-1 § 2810.1.D that "the hospital is assumed to have budgeted based on prior year utilization and to have had insufficient time in the year in which the volume decrease occurred to make significant reductions in cost." This approach is also consistent with the directive in 42 C.F.R. § 405.108(d)(3)(i)(A) that the Medicare contractor must "consider[]. . . . [t]he individual hospital's needs and circumstances" when determining the payment amount.[68] Clearly, when a hospital experiences a decrease in volume, the hospital should reduce its variable costs associated with the volume loss, but the hospital will always have some variable cost related to furnishing Medicare services to its *actual* patient load.

Critical to the proper application of the statute, regulation and PRM provisions related to the VDA, are the unequivocal facts that: (1) the Medicare patients to which a provider furnished *actual* services in the current year are not part of the volume decrease, and (2) the DRG payments made to the hospital for services furnished to Medicare patients in the current year is payment for *both* the fixed and variable costs of the *actual* services furnished to those patients. Therefore, in order to fully compensate a hospital for its fixed costs in the current year, the hospital must receive a payment for the variable costs related to its *actual* Medicare patient load in the current year as well as its full fixed costs in that year.

The Administrator's methodology clearly does not do this, as it takes the portion of the DRG payment intended for variable costs and impermissibly characterizes it as payment for the hospital's fixed costs. The Board can find no basis in 42 U.S.C. § 1395ww(d)(5)(G)(iii) allowing the Secretary to ignore 42 U.S.C. § 1395ww(a)(4) – which makes it clear that the DRG

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[66] *St. Anthony Reg'l Hosp.*, Adm'r Dec. at 13; *Trinity Reg'l Med. Ctr.*, Adm'r Dec. at 12.
[67] 42 U.S.C. § 1395ww(d)(5)(G)(iii).
[68] The Board recognizes that 42 C.F.R. § 405.108(d)(3)(i)(B) instructs the Medicare contractor to "consider[]" fixed and semifixed costs for determining the VDA payment amount but this instruction does not prevent payment through the DRG of the variable costs for those services *actually* rendered.

payment is payment for both fixed and variable costs - and deem the entire DRG payment as payment solely for fixed costs. The Board concludes that the Administrator's methodology does not ensure that a hospital, eligible for a VDA adjustment, has been fully compensated for its fixed costs and, therefore, is not a reasonable interpretation of the statute.

Finally, the Board recognizes that, while PRM 15-1 § 2810.1 and 42 U.S.C. § 1395ww(d)(5)(G)(iii) do not fully address how to remove variable costs when calculating a VDA adjustment, the VDA payment is clearly not intended to fully compensate the hospital for its variable costs. [69] Additionally, based on 42 U.S.C. § 1395ww(a)(4), the Board finds that DRG payments are intended to pay for both variable and fixed costs for Medicare services actually furnished. The Board concludes that, in order to ensure the hospital is fully compensated for its fixed costs *and* be consistent with the assumption stated in PRM 15-1 § 2810.1 that "the hospital is assumed to have budgeted based on the prior year utilization," the VDA calculation must compare the hospital's fixed costs to that portion of the hospital's DRG payments attributable to fixed costs.

As the Board does not have the IPPS actuarial data to determine the split between fixed and variable costs related to a DRG payment, the Board opts to use the Medicare Contractor's fixed/variable cost percentage as a proxy. In this case the Medicare Contractor determined that Nathan Littauer's FY 2011 fixed costs (which includes semi-fixed costs) were 86.82 percent[70] of the Provider's Medicare total costs for FY 2011. The Board also recognizes that the fixed/variable cost percentage should not be used in the calculation of the cap. Applying the rationale described above, the Board finds the VDA in this case should be calculated as follows:

Step1: Calculation of the Cap

2010 Medicare Inpatient Operating Costs	$ 10,273,271[71]
Multiplied by the 2011 IPPS update factor	1.0224[72]
2010 Updated Costs (max allowed)	$ 10,499,283
2011 Medicare Inpatient Operating Costs	$ 11,567,614[73]
Lower of 2010 Updated Costs or 2011 Costs	$ 10,499,283
Less 2011 IPPS payment	$ 8,236,227[74]
2011 Payment Cap	$ 2,263,056

Step 2: Calculation of VDA

2011 Medicare Inpatient Fixed Operating Costs	$ 10,043,002[75]

[69] 48 Fed. Reg. 39752, 39782 (Sept. 1, 1983).
[70] Stipulations at ¶ 11.
[71] *Id*.
[72] The IPPS Update Factor for Federal Fiscal Year (FFY) 2011 is 1.0235 and for FFY 2012 is 1.019. As Nathan Littauer's fiscal year has 273 days (1/1/11 to 9/30/11) in FFY 2011 and 92 days (10/1/11 to 12/31/11) in FFY 2012, the proper factor is as follows ((273 x 1.0235) + (92 x 1.019)) / 365 = 1.0224 rounded
[73] Stipulations at ¶ 11.
[74] *Id*.
[75] *Id.* (Calculation = $11,567,614 x 86.82 percent = 10,043,002, rounded).

Less 2011 IPPS payment – fixed portion (86.82[76] percent)	$ 7,150,692[77]
Payment adjustment amount (subject to cap)	$ 2,892,310

Since the payment adjustment amount of $2,892,310 is **greater** than the cap of $2,263,056, the Board determines that Nathan Littauer's FY 2011 VDA payment should be $2,263,056. On May 27, 2016, the Medicare Contractor issued a VDA payment in the amount of $1,091,330[78]; therefore, Nathan Littauer should receive an additional VDA payment of $1,171,726 for FY 2011.

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor improperly calculated Nathan Littauer's VDA payment for FY 2011, and that Nathan Littauer should receive an additional VDA payment of $1,171,726 for FY 2011, resulting in a total FY 2011 VDA payment of $2,263,056.

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2/29/2024

X Clayton J. Nix

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Board Chair
Signed by: PIV

[76] *Id.*
[77] The $7,150,692 is calculated by multiplying $ 8,236,227 (the FY 2011 DRG payments) by 0.8682 (the fixed cost percentage determined by the Medicare Contractor).
[78] Provider's FPP at 4-5; Exhibit P-2.